COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
APPROVAL OF BENEFITS

(COUNTY STAMP)

Case name: _____
Case number: _____
District: _____
This affects: _____
_____
(Names)

Your application for CMSP benefits has been approved.

❒ You are entitled to receive CMSP benefits beginning the first day of _____. You will receive your plastic Benefits Identification Card (BIC) soon. ***Do not throw this card away.*** This card is good as long as you are eligible for CMSP. Take this plastic card to your doctor or other Medi-Cal provider when you request medical services.

❒ Since your income exceeds the amount allowed for living expenses, you have a share-of-cost to pay or obligate toward your medical care. Your share-of-cost is $_____ beginning _____. Your share-of-cost was computed as follows:

Gross Income	$_____
Net Nonexempt Income	$_____
Maintenance Need	$_____
Excess Income/Share of Cost	$_____

Take your plastic card with you each time you receive medical care. Your Plastic Card will show your provider if you have a share-of-cost to pay. The amount that you pay or obligate to the medical providers will be automatically computed. After your total share-of-cost has been paid or obligated, you will not have to pay for medical services received that month from Medi-Cal providers.

The regulations which require this action are California Administrative Code, Title 17, Section(s): 1498, et seq.

_____ _____ _____
Eligibility Worker Phone Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE